



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE NEAR FATALITY OF:



Date of Birth: 10/04/2011
Date of Incident: 04/14/2014
Date of Oral Report: 04/14/2014

FAMILY KNOWN TO:
Crawford County Children and Youth Services

REPORT FINALIZED ON:
May 14, 2015

This report is confidential under the provisions of the Child Protective Services Law and cannot be released.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DHS must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Crawford County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	Victim Child	10/11/2011
[REDACTED]	Sister	[REDACTED] 2012
[REDACTED]	Brother	[REDACTED] 2009
[REDACTED]	Mother	[REDACTED] 1990
[REDACTED]	Father	[REDACTED] 1991

Notification of Child Near Fatality:

The Department of Human Services was notified of this incident on April 15, 2014, although Crawford County Children and Youth received the Child Protective Services (CPS) report the day prior. According to the report, the mother was awoken by her four year old son screaming that his younger brother was "dying" and that she needed to "save him."

The report said that the boys had found their father's loaded semi-automatic pistol in a drawer and the four year old brother claimed that the victim child shot himself in the face. When the mother saw the victim child, she immediately called the father at work and then called 911. The child was flown to Children's Hospital of Pittsburgh (CHP) via medical helicopter.

Upon arrival at CHP, it was determined that the bullet entered through the child's cheek and, according to the initial report, through his brain. The child had a broken cheekbone, multiple [REDACTED], and lacerations to his right hand. Because of the injuries, one of the physicians at CHP certified the report as a near fatality. The child was, however, alert and able to speak the day after the incident. The initial report stated that the [REDACTED] do not believe that a two or four year old could have pulled the trigger on the handgun.

Summary of DHS Child (Near) Fatality Review Activities:

The Western Regional Office of Children, Youth and Families reviewed the case record [REDACTED]. In addition, this writer participated in the Act 33 review meeting, which was held on May 13, 2014. As part of the case record, the Department was also provided with the medical report from CHP.

Children and Youth Involvement prior to Incident:

Prior to the near fatality report, the Crawford County Children and Youth Services (CYS) had one General Protective Services (GPS) referral on the family that was received on May 16, 2012. The allegations were that the four year old child was sexually acting out on his cousins and possibly other children. According to the report, the reporting source was [REDACTED]. The reporting source stated that the parents weren't "receptive" to talking about the issues. The report was given a 24 hour response time.

At the time of the report, the mother was pregnant with the youngest child. The worker made contact with the family on May 17, 2012 and saw both boys and their parents. The worker discussed the concerns with the parents. The parents reported that the child that has been initiating the sexualized behaviors was the paternal aunt's son, who has been displaying these behaviors for over a year. Reportedly, the aunt's mother eventually took that child from the aunt and was caring for him. The worker explained that since their child was exposed to inappropriate behavior, they should seek services to deal with it. The worker provided them with the name of a provider for the child. The caseworker completed a safety assessment worksheet on this date, with the determination of "Safe" for both children.

On May 18, 2012, the grandmother contacted the caseworker and confirmed that the other child was the initiator and the only time her other grandson gets involved in those types of behaviors is when he is around his cousin. The grandmother had recently found the cousin naked and on top of a female cousin.

The agency closed the case on May 21, 2012, as they determined that the other child was the initiator and the parents were protective of their child. The parents were also given a resource to take the child [REDACTED].

Circumstances of Child (Near) Fatality and Related Case Activity:

On April 14, 2014, the agency received a report from the [REDACTED] that the victim child, who was two and a half years old at the time, shot himself in the face with a Ruger LCR 380 caliber, semi-automatic handgun. The gun was loaded and in a drawer in the family home. At the time of the incident, the father was at work and the mother was responsible for supervising the children. The children were playing in the home (which is a trailer) and allegedly running in and out of the master bedroom. The mother fell asleep on the couch and was woken up by her four year old son screaming that the victim child "was dying" and for her to "save him."

[REDACTED] stated that the four year old claimed that the child shot himself, but this had yet to be verified. The father initially said that the gun didn't have the magazine in it, but after further questioning [REDACTED], admitted that it did. [REDACTED] reported that it would have been "impossible for a two or four year old to pull the trigger" unless there was a bullet in the chamber. [REDACTED] also described the home as "words cannot describe" and stated that "a rat wouldn't live there." [REDACTED] reported that there were human feces on the walls, a walled-

off room with a plywood gate where the children were put to play, and "gelatinous things" on the bed. [REDACTED] was able to see the child, but the child was being [REDACTED]. At that time, the child had brain matter coming out of his ear, his face was distended, and he still had the bullet in his head behind the right ear. It was unknown if he was going to survive at the time [REDACTED] was making the report.

On April 14, the on-call worker contacted the on-call supervisor, who instructed the worker to have Allegheny County Children, Youth and Families (ACCYF) make a courtesy visit to the hospital to see the child. ACCYF agreed to do so and would email the information to Crawford County CYS.

According to ACCYF's case note, the worker made contact with the child and family at 9:55 AM on April 15, 2015. The child was talking and aware of what was going on and the nurse said the child was in stable condition at that time. The worker spoke with the father, who said he was running late in the morning and forgot to take the handgun with him. He said the weapon is normally kept "in the top of the dresser underneath all of the clothes," but he was unsure when the children saw him put it in there. He has a permit to carry and carries it on his hip daily and said that he purchased it for protection. He admitted that it was loaded in the home because it is "always loaded." He does not own gun locks for any of the weapons (two additional guns) in the home. The father was having a hard time coping with what happened because he blames himself. The father said that he works 7 AM to 3 PM and the mother works from 3 PM to 11 PM so daycare was not necessary. The father was concerned about the condition of the home if a home visit was conducted. He reported that the children had gotten into an "egg battle" and there were cracked eggs all over the place, a "clothes battle," and the dog had gotten into the garbage and it was strewn all over the house.

On April 15, the supervisor contacted the father. The father reported that the child was doing "ok" and his vitals were fine. He was alert and able to talk, reportedly asking for "daddy." The other children were staying at his mother's home. When the father realized that the supervisor was from CYS, the father began to cry and asked if the agency was going to remove the children. He stated that Troopers took the firearm that caused the injury and his father took the other guns to lock in the grandfather's attic. The father also said he was getting rid of his collectible knives. The father was advised that the two other children needed to be seen. The family was temporarily staying with his mother, stepfather, and sister in [REDACTED]. The supervisor told the father which worker was assigned to the investigation. The father informed the supervisor that Allegheny County CYF had contacted them at the hospital.

Also on April 15, the assigned worker contacted the social worker to gather more information. The social worker wasn't aware that this was an active CPS investigation, even though he acknowledged that PSP had been to the hospital for the child. At that time, the child was doing "amazingly well" and was able to move his arms and legs, was talking well, and breathing on his own. There were [REDACTED], but they had to wait until the swelling went down [REDACTED]. The child would also need [REDACTED]. The social worker said that they had been observing interactions between the father and child and they believed the interactions to be good. The mother was with the other children, but coming back to CHP.

A home visit at the residence where the children were staying was completed by the assigned worker on April 15. The children were seen, but not interviewed regarding the incident. The home was deemed appropriate, without safety threats.

The worker also spoke with [REDACTED] again, who expressed concern with the family. He wanted to schedule a forensic interview for the brother, which the worker was in agreement with. [REDACTED] also stated that the family's actions were "bizarre" because before the family left for CHP the day of the incident, they went back to the house to get drinks. A supplemental report to this investigation was received on April 15. It documented the incident and the medical findings for the child. It also recommended that the siblings be examined to ensure they are medically safe. The reporting source had concerns for the supervision of the children. (This supplemental is what registered the CPS as a near fatality.)

A home visit at the family's residence was completed on April 16, 2014 by the assigned worker and her supervisor. The home conditions were poor, with clothes, garbage, and other items all over the floor. Many of the register vents in the home were missing, leaving a hole in the floor. During this visit, the youngest child was found "locked" in her room. There was a piece of wood between the floor and the door to prevent the door from opening. The father removed the piece of wood, looked in, and stated the child was waking up. When the supervisor looked into the room he saw the child sleeping on the floor, lying on top of clothes and other items ("garbage", etc.). The supervisor observed dog feces near the child's head. When the workers addressed the safety issues with this practice, the parents asked what they were to do to keep the child from getting out and getting into things while they are sleeping.

The family was advised that due to the conditions of the home and the fact that they were locking a child in her room, a safety plan should be developed. It was decided that the family would drive to the grandmother's home, where they would assist in safety plan development. The parents were tearful and the workers stressed to them that it's just not the condition of the home that is concerning, but it's also their parenting abilities. In the corresponding safety assessment the worker identified a present safety threat. As a result, a safety plan was developed at the grandparents' home which had the children remaining in the care of the grandparents until further notice from the agency. The grandparents' home was deemed appropriate for the children to temporarily stay.

The victim child's brother had a forensic interview conducted on April 17, 2014. The brother initially stated several times that the victim shot himself but then said that he was told by his father not to tell. He eventually said that he was playing with the gun with the victim child, but did not admit to shooting the victim. The child also spoke a lot about someone named "Richard" that comes to the home, but the family denied knowing anyone by that name and the brother later told his parents that "Richard" is his imaginary friend.

After the brother's interview, the mother was interviewed by [REDACTED], casework supervisor, and caseworker. The mother admitted to falling asleep on the couch for about one hour before she was awoken by the victim's brother. She said that she didn't hear the gunshot. She denied knowing that the gun was in the home, but later contradicted herself by saying she could believe it was in the dresser because that's where the father takes it off at night. Later, she also said the gun had been in the home for three weeks and the father carries it loaded. The mother believes that the brother shot the victim because she doesn't believe the victim could have done it to

himself. She also admitted that they would put plywood across the children's doors to keep them in their room while they were sleeping, but denied leaving them in there. She did think it was possible that the father put the kids in there while she was at work and the father was trying to get things done. She denied that the father told the brother to keep what had happened a secret, but the father is concerned about going to jail because it was his gun. The mother denied taking any drugs that day and stated she was just exhausted.

The father was interviewed again. He was at work when the incident happened and came home right away. The mother told him that she initially thought that the victim had fallen, but then realized he had gotten hold of the gun. The father denied telling the brother not to say anything and also believes that the brother shot the victim accidentally. The father continued to deny that a round was left in the chamber and told [REDACTED] that the brother knows how to put one in and that the brother could pull the slide back. [REDACTED] told the father that he didn't believe this was possible, but the father maintained that he could. The father said he "thought about the gun the entire day" of the incident because he normally takes it with him and locks it in his truck during work. He ran late that morning and forgot about it. The father later admitted that he normally carried the gun with one round in the chamber, but clears it when he puts the gun away. He was also pretty sure he cleared the chamber the day of the incident. The father also admitted that he has allowed the brother to pull the trigger on another handgun. As of this date, all of the guns had been removed from the home. The family agreed to cooperate with [REDACTED].

The victim child [REDACTED] on April 22, 2014 to the care of his grandparents and with his siblings. On April 24, the worker conducted an unannounced home visit to the grandparents' home. All three children were seen and the victim child was described as "very happy and playful." The grandmother reported that the children had been adjusting well. The parents visited the children often and were spending a lot of time preparing their home for the children's return. The worker made the grandmother aware that concerns for their supervision of the children still existed. She understood this. The father's guns are locked in the attic of the grandparents' home and they are unable to get to the attic because the door is locked.

After visiting with the children and grandparents the worker went to the family home. The home was "100% better" than the first time the worker was in the home. The worker obtained releases of information, discussed necessary referrals for services for the family, and advised the family that their case was going to be opened for services. The parents maintained that they would not bring any more weapons back into the home.

The family continued to work with the agency and completed initial referrals and assessments recommended to them. [REDACTED] was working with the family on a regular basis (twice per week).

On May 16, 2014 the county held their Multidisciplinary Team (MDT) meeting to review the investigation. The worker was still gathering more information to support their finding prior to completing the CY-48.

A Family Group Decision Making (FGDM) meeting was held on May 29, 2014 to help the family develop a safety plan for the children.

On May 30, 2014 the agency completed their CPS investigation by submitting the CY-48 with an "Indicated" status, listing both parents as perpetrators (the family's case had already been accepted for service on April 25). The police were pursuing charges, but had yet to arrest either parent at that time.

Current Case Status:

The children remain in formal kinship care and have supervised visits with the parents twice per week for a total of 5 hours. The children were removed from their original caregivers, the paternal grandparents, in July 2014 due to supervision concerns. The children are doing well, including the victim child. He has been released from all medical care and no longer [REDACTED]. The only physical sign of the trauma is a small scar on his cheek. The children's current placement goals are to return home, however, [REDACTED] other options are going to be discussed with the parents. The parents continue to have difficulty appropriately caring for their children even during visits (i.e. parents sleeping during visits, not feeding the children a meal, etc.). The family continues to work with services and have completed [REDACTED], they are attending [REDACTED] with the victim child's brother, and they continue to work with the [REDACTED] services referred by Crawford Co. CYS.

On July 8, 2014, both parents were arrested and charged with crimes related to the incident. The father was charged one count of Recklessly Endangering another Person (REAP) and two counts of Endangering the Welfare of Children (EWOC). According to the court summary, on December 18, 2014, the father pled guilty to one count of Felony EWOC and the REAP charge. On February 24, 2015 he was sentenced for a minimum of 11 months 15 days/Maximum 23 months 29 days for the EWOC charge and a maximum of two years of probation for the REAP charge. The second EWOC charge was nolle prossed.

The court summary for the mother shows that she plead guilty to her third degree felony count January 8, 2015 and was sentenced to a minimum of 67 days/maximum 23 months 29 days confinement and 60 months of probation. The caseworker, however, reported that the mother's sentence is three months house arrest with an ankle monitor and 60 months of probation.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

According to the county report, the following areas were noted:

- **Strengths:**
 - The information was gathered diligently by the intake department.
 - The investigation began immediately and within hours, the agency had contacted ACCYF for a courtesy contact.
 - Mandated paperwork was completed routinely and timely.
 - Appropriate referrals were made for the family.
 - The agency intake and ongoing departments collaborated efficiently and effectively, as the case was transferred to ongoing while the investigation still occurred.
 - Kinship resources were engaged effectively.
- **Deficiencies:**

- None identified.
- Recommendations for Change at the Local Level:
 - The recommendations in the report were case/family specific and not system related.
- Recommendations for Change at the State Level:
 - There were no recommendations at the state level.

Department Review of County Internal Report:

The Department received the county's internal report on May 14, 2014. The report was very well written and detailed. The Department is in agreement with the findings. This was related to the agency at the MDT held on May 16.

Department of Human Services Findings:

- County Strengths:

The agency responded quickly, worked cooperatively with law enforcement, and was diligent in addressing the identified issues. They were communicated their concerns for the parents very well to the parents, caregivers, and providers. The agency also made appropriate referrals, including in-home, substance abuse, mental health, and trauma therapy.

Also, Crawford County CYS does a very good job of completing their internal reports and they are very organized related to scheduling MDT meetings, which are always well attended.
- County Weaknesses:

The Department could find no weaknesses with this investigation.
- Statutory and Regulatory Areas of Non-Compliance:

The agency was in compliance with all regulations for this investigation.

Department of Human Services Recommendations:

The agency should continue to utilize their current process for conducting these reviews. As stated above, the meetings are very organized, informative, and well attended.